WOMEN AND HEALTH

A critical review of available information in India

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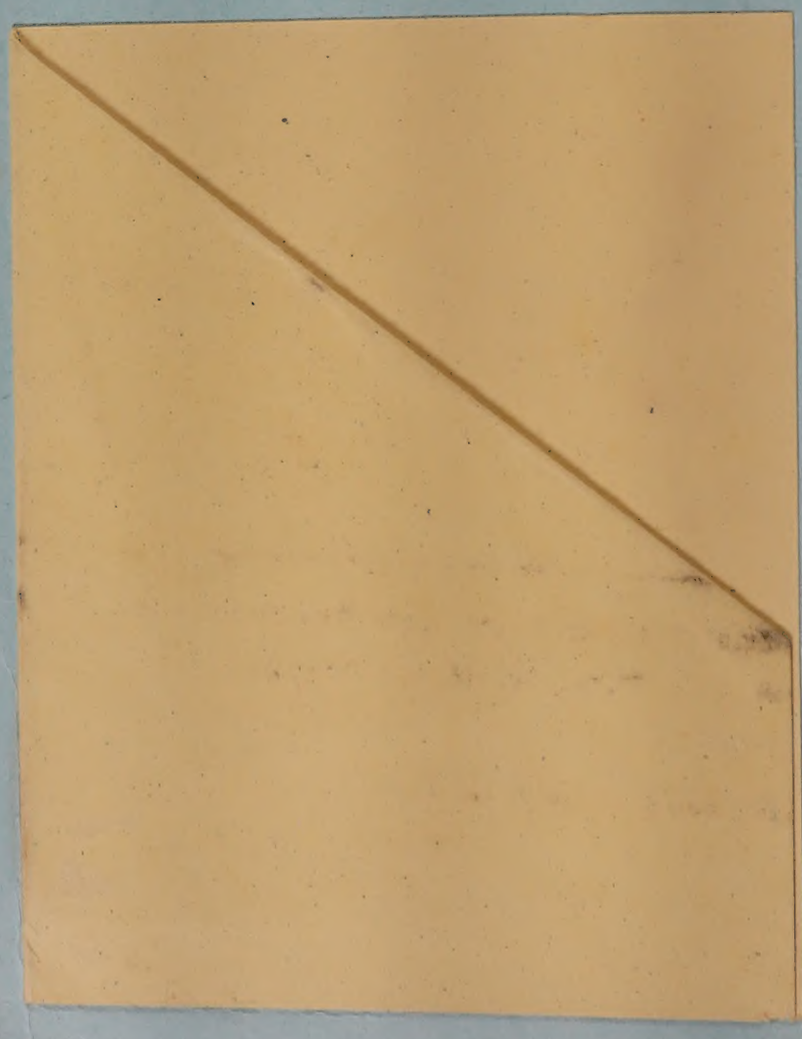
F.R.CH

March 1984



WOMEN AND HEALTH :

A CRITICAL REVIEW OF AVAILABLE INFORMATION IN INDIA

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NOTE

This paper is a revised version of a chapter entitled, "Women and Children's Health", in a forthcoming publication, "Health for All : An Alternative Strategy : Supplementary Document", Indian Council of Medical Research.

While working on the chapter, and through discussions with several people, the authors felt that this would be a useful set of data, both for people in the field of health as well as women concerned with feminist issues. Although the paper does not make any new hypotheses, the value lies in the fact that information from various sources has been collected collated and analysed.

Please feel free to use any part of this material, giving credit and acknowledgement wherever due.

INTRODUCTION :

It is accepted today that women as a group suffer a wide variety of disadvantages even in the most developed nations in the world. It is in this context that a fresh look at the existing health system is necessary to see whether the facilities are sensitive to the situation of women. Since the United Nations' declaration of the International Year of the Women, in 1975, much has been published on various aspects of the life and work of women. This is an attempt to compile and analyse data from various sources relating to the health of women in India.

Health problems of women have been broadly divided into two categories (Britto and Daswani, 1984) :

(a) Illnesses which arise because of and attendant upon their reproductive structure and function; and

(b) Health problems aggravated due to social taboos, customs and the overall structure of society and it's processes.

It is difficult to compartmentalise the problems. For example, repeated pregnancies are health hazards relating to the reproductive structure of women. However they occur primarily due to the socio-economic and cultural conditions prevalent in most parts of the country.

It has been recognised that women face health problems throughout their life cycle (WHO, 1978) starting from sex preferences during infancy, discrimination in feeding practice biological vulnerability of women during the reproductive period, the effect of a high level of fertility, to special problems such as nutritional anaemia and maternal mortality.

In this paper, available data has been collected for the various health problems affecting women during various stages of their growth. Wherever possible, the information has been related to the prevalent socio-economic conditions. There is a large section on ailments pertaining to the reproductive structure and function, primarily because the bulk of statistics relate to this aspect. The nutrition of women has been viewed in relation to the work they perform. Contraception has not been touched upon, since it was felt that it warrants a separate analysis. Utilisation of health services in the country and the role of women as health personnel have been included at the end.

AMNIOCENTESIS :

The test came into clinical use in the US in 1969, in order to detect congenital abnormalities. In India, it is used as a tool for sex discrimination even before the infant is born. The concept of "plan the sex of your baby" spread widely during the early eighties and doctors advocate it as a

means of family planning in spite of the fact that it would result in a lop-sided sex ration (Gokhale and Gupta, 1983). In 1982, a prominent male gynecologist claimed to have conducted at least 6000 tests, averaging 8-10 cases per day (Times of India, 5th September 1982). The Medical Termination of Pregnancy Act of 1971 has no provision against the selective killing of females, although it permits abortions of only upto 20 week old foetuses. That the tests are conducted during the 24th week of pregnancy, and abortion during the second trimester carries a risk to the health of the woman does not retard the practice. The infections developed by women during the process of the extraction of the amniotic fluid are usually not publicised.

During a recent seminar on Genetic Counselling held in Bombay, a male obstetrician from a reputed hospital admitted that the test was not 100% fool-proof (Grant Medical College, 1983). There had been cases of damage to the foetus, as well as one incident where a woman died after the test, due to septic infection. That this death was publicly reported, unearths the possibility that several may remain concealed. It was disturbing to hear a reputed member of the medical profession discuss merely the technical aspects of the test with no concern whatsoever about the risks to the woman, and the ethical implications of female foeticide.

An analysis of a small sample of 50 women conducted to determine who was using the test, revealed that more than 90%

of the women had no male child and 88% had one female child (Savara, 1982). After around mid-1982, when it was widely written about, there is little information available in the press.

INFANT MORTALITY :

According to available statistics (Central Bureau of Health Intelligence, 1983) there is a higher rate of infant mortality among females.

Table - I

Infant Mortality (expressed as no. of deaths per 1000 live births)

AREA	SEX		
	Males	Females	Persons
Rural	130	142	136
Urban	69	71	70
T O T A L	120	131	125

The Foundation for Research in Community Health has a detailed analysis of the mortality profile in their rural health project, (henceforth referred to as the Mandwa projec 15 km. from Bombay city (Batliwala, 1983a, Daswani, 1984). In 1982 it was observed that among the deaths occuring in the age group 0-5 years, 64% were female. It was hoped that this would be an anomaly, however the pattern was repeated i 1983.

A further analysis in relation to the age-structure in that group was done.

Table - II

Age v/s Sex Distribution of 0-5 Mandwa Deaths

AGE GROUP	SEX			
	Male		Female	
	(no.)	(%)	(no.)	(%)
0-30 days	19	49%	20	50%
1 month - 5 years	7	32%	15	68%
T O T A L	26		35	

While in the neo-natal period the number of female and male deaths are roughly equal, after one month of age the female deaths are more than double that of male deaths. It is a well-known phenomenon that neo-natal mortality of female infants is followed by systematically higher mortality beyond this period (Sen and Sengupta, 1983).

An examination of the causes of death reported with relation to sex distribution reveal the following :

Table - III

Cause of Death v/s Sex in Mandwa

(A) CAUSE OF DEATH (0-30 days)	NUMBER		TOTAL
	Male	Female	
1) Premature/Small for Date	7	8	15
2) Stillbirths	6	5	11
3) Unknown	-	5	5
4) Abortion	2	-	2
5) Fever	2	1	3
6) Problems during Delivery	2	-	2
7) Asphyxia	-	1	1
T O T A L	19	20	39

(B) CAUSE OF DEATH (30 days - 5 years)	NUMBER		TOTAL
	Male	Female	
1) Malnourishment	1	4	5
2) Diarrhoea	-	3	3
3) Fever	1	2	3
4) Measles	2	4	6
5) Tuberculosis	2	1	3
6) Unknown	1	1	2
T O T A L	7	15	22

It is particularly distressing to note that all five deaths reported as "unknown" in the neo-natal period are female. During this period, the number of deaths due to conditions such as still births and premature deliveries - which cannot be controlled, are roughly equal. However after one month of age, not only are the number of female deaths significantly higher, but also the causes such as diarrhoea and malnourishment are easily preventable. Although the sample size is small, it is reluctantly admitted that the trends observed seem to signify a greater neglect of female children.

SEX BIAS IN INFANT MALNUTRITION :

There is evidence to show that there is a comparative neglect of female babies and children, especially in North India. The extent of discrimination may be heightened during an economic crisis such as the floods of 1978 in West Bengal, wherein the incidence of female children malnutrition was substantially greater than that of their male counterparts (Kunch and Sen, 1983).

An interesting study based on empirical field data was conducted in two villages in West Bengal (Sen and Sengupta, 1983). The study is summarised below :

Table - IV

Village Profile v/s Malnutrition

SAHAJAPUR VILLAGE	KUCHLI VILLAGE
205 households	126 households
metalled road to town (7 km)	isolated from town(15 km)
leftwing, high political activism	ditto
nil	active land reform
60% population landless	18% landless
direct nutritional intervention programme	nil

UNDERNOURISHMENT INDEX* OF UNDER-5's

Total	54	Total	48
Males	53	Males	39
Females	55	Females	55

*Note, the higher the figure, the greater the extent of malnutrition.

The average overall nutritional record of Kuchli is higher than that of Sahajapur. Given that landownership is an adequate index of economic prosperity, it is clear that the level of malnutrition decreases as landownership increases. This was also evident in the children of landed v/s landless parents in both villages.

In terms of the sex bias, the discrimination was much sharper in Kuchli. The undernourishment index of the girls was identital in both villages, however the male children in Kuchli are significantly better off. It seems that the economic benefits vis-a-vis the land reforms have primarily benefited the boys. On the other hand, in Sahajapur the direct nutritional intervention through supplementary feeding has affected both the male and female children in the family.

Whether such nutritional programmes should be used to combat the sex bias in food distribution within a family is a debatable issue. It is clear from this study that improvement of the economic situation does not elevate the status of women - in fact it creates a greater level of discrimination by increased advantage to the males.

ADOLESCENT PREGNANCIES :

In India, a large percentage of girls are married before they complete their teens. In a study conducted among 381 women construction workers in Delhi, 13.4 per cent were married in the age group 5-9 years and 38.6 per cent in the age group 10-14 years (D'Souza, 1979). This study is useful only to indicate that in certain poorer sections of our society, the problem of adolescent pregnancies might be very acute.

Table V presents the mean age at marriage for all India (Agarwala, 1972).

Table - V

Mean Age at Marriage 1901 - 1971

YEAR	MALE	FEMALE
1901 - 1911	20.2	13.2
1941 - 1951	19.8	15.4
1961 - 1971	22.2	17.2

In the year 1971, 13.6% of the girls between 10-14 years were reported to be married in rural areas and 3.9% in urban areas. This is in contravention of the Child Marriage Restraint Act which prescribes the minimum age for the female at 15 years.

Risks of pregnancy and obstetric complications are particularly high under 16 years of age. Toxaemia of pregnancy is significantly higher among young adolescents as compared to other age groups. In addition, low birth weight babies are also born more frequently.

The yearbook of the department of family planning, (Government of India, 1983) presents data for the years 1978 - 1981 on the age-wise distribution of cases coming for medical termination of pregnancy (MTP). A total of 3,918 MTP requests (0.5%) were from girls below the age of 15 years. This is probably an underestimation, and the incidence of pregnancy among married and single adolescent girls is likely to be higher than the figures available.

PROBLEMS RELATED TO PREGNANCY :

During the prime reproductive age (15-45 years) the average Indian woman becomes pregnant about 8 times (Jayarao, Kamala, 1983). She may ultimately be left with only 3-5 children due to adverse survival conditions. Each liveborn infant is generally fed up to 2-3 years of age.

Table - VI

TIME SPENT BY AN AVERAGE INDIAN WOMAN IN PREGNANCY AND LACTATION

	MONTHS
Total reproductive life span (15-45 years)	360
Total duration of Pregnancies	
7 live births	63
1 abortion	5
Total average duration of lactation	
1 death in infancy	6
6 survivals beyond 1 year	120
Total time spent in Pregnancy and lactation	194

Thus out of the total 360 months of reproductive life, 200 months or 50-60% of the time is spent in pregnancy and lactation. Of this, some 140 months are completed before the woman reaches 35 years of age.

Not only that, but there is no increase in food intake even though the requirements go up during pregnancy and lactation. The poor nutritional status is also evident in the high proportion of premature and small for date deliveries, accounting for nearly one-third of the infant deaths in the Mandwa Project (Batliwala, 1983a, Daswani, 1984).

A study conducted by Muthaia in 1972 showed that 30 per cent of the respondents reported ailments during pregnancy. Their complaints included indigestion, vomiting, headache, bodyache and oedema. Some of these ailments suggest a lack of ante-natal care. An Orissa medical Journal also claims that the death rate was high among women during their first pregnan and 92% of them had never attended the ante-natal clinic (The Telegraph, 17th January 1983).

Muthaia's study also found that 31 per cent of the respondents had more than seven children. The expecting mother was given only the normal rest as availed by others in the household, both between 0-5 months and 5-9 months of pregnancy. It is important to note that more rest was not thought to be necessary either because they were not aware of such a requirement or could not afford the luxury of rest. 29% of the women were given less than 2 months rest after delivery. 99.6 per cent of the women attended to household work during 0-9 months without any break and 65.9 per cent attended to normal manual work.

This excessive burden results in over depletion of the woman's body resources as well as a high degree of foetal wastage. The longitudinal studies in human reproduction carried out by the Department of Biostatistics of Christian Medical College revealed that the rate of foetal deaths per thousand pregnancies was 32.8/1000, nearly half that of the urban areas, 66.1/1000. The foetal death rate for the first pregnancy in the rural areas was higher, 37.3/1000. In the urban areas it was only the fourth and subsequent pregnancies which had the highest foetal death rates 74.6/1000. The report does not explicitly distinguish abortion and spontaneous wastages.

ABORTION :

It is generally estimated that about 50 per cent of all pregnancies are not carried to completion. Although abortion should not be a method of family planning, induced abortion is probably the most widely used method of fertility regulation. Each year 40-70 per 1000 women of the reproductive age have an abortion (Britto and Daswani, 1984).

For the majority of women wanting an abortion, health services are not accessible, both physically or financially. The yearbook of the Department of Family Planning and Welfare (Government of India, 1983) presents data on medical termination of pregnancy (MTP) cases by duration of pregnancy. It is surprising to see that for three years (1978-81) an average of 15.26 per cent of all MTPs were during the second trimester. This is dangerous for women's health, especially

with the kind of health structure existing in the rural areas. That so many women came for an MTP in the 12-20th weeks of their pregnancy does not speak well of family planni education among the masses.

The same volume also presents the distribution of MTP cases by reasons during 1978-81. A summary of the table is presented below :

Table - VII

REASONS FOR MTP (1978-81)

REASONS	YEARS	NO. OF CASES	PERCENTAGE
Failure of contraceptives	1978-1979	157107	48.9
	1979-1980	141274	47.3
	1980-1981	103064	46.7
Pregnancy caused by rape	1978-1979	4770	2.2
	1979-1980	7713	2.6
	1980-1981	6756	2.1
Danger to life	1978-1979	10636	4.8
	1979-1980	16560	5.6
	1980-1981	19141	6.0
Grave injury to physical health	1978-1979	35772	15.6
	1979-1980	52139	17.5
	1980-1981	51826	16.1
Grave injury to mental health	1978-1979	34327	15.6
	1979-1980	46038	15.4
	1980-1981	44055	13.7
Substantial risk	1978-1979	10989	8.7
	1979-1980	18563	6.2
	1980-1981	23589	7.4
Not available	1978-1979	36276	10.2
	1979-1980	47960	13.8
	1980-1981	39963	12.0

It is interesting to note that the highest percentage of MTPs performed in all the age groups listed were due to failure of contraception (annual percentage around 47%). Indeed, a clear case for an emphasis on the health education aspect of the family planning programmes.

In three years there have been 19,239 women who have sought to terminate pregnancy on the grounds that it was caused by rape. It is a high figure, however the actual figures of rape cases must be much more, given the social constraints under which women would seldom reveal that they have been raped.

The number of deaths per 1000 MTPs conducted is reported to be of the order of 0.1. Percentage deaths due to abortion among all causes of maternal deaths in rural areas for the age groups 15-44 are given below :

Table - VIII

PERCENTAGE OF DEATHS DUE TO ABORTION IN RURAL AREAS FOR THE AGE GROUPS 15-44 YEARS

AGE GROUP	PERCENTAGE OF MATERNAL DEATHS
15 - 24	13.7%
25 - 34	8.1%
35 - 44	21.2%

The death information analysis of the Foundation for Research in Community Health, Mandwa Project revealed certain significant trends in the seasonal distribution of infant deaths (Batliwala, 1983a, Daswani, 1984). In both the years,

40-50% of the total no. of infant deaths occured during the monsoon period. While it is not unusual to expect that the monsoon climate would aggravate the incidence of water borne diseases, the data called for further disagregation and analysis.

The data was broken down taking only infant deaths, and two month intervals were used :

Table - IX

SEASONAL VARIATION OF INFANT DEATHS (0-1 YEAR)

MANDWA PROJECT

	1982		1983	
	Infant Deaths	% of Total	Infant Deaths	% of Total
January February	6	16%	8	15%
March April	4	10%	11	21%
May June	8	21%	4	78%
July August	14	37%	13	25%
September October	1	3%	11	21%
November December	5	13%	6	11%
	38		53	

From table IX, it is evident that the highest proportion of infant deaths occur during July and August. Moreover the cause of death during this period was largely due to still births and premature deliveries. The only unique feature about these months is that they comprise the sowing season. In agricultural areas such as these, every pair of hands, including those of pregnant women are required in the fields from morning to dusk during sowing operations.

Obstetricians confirm that if women in the last trimester of pregnancy engage in such intense physical activity, particularly the squatting position which is employed for tasks like transplanting and weeding, there is continuous pressure on the uterus, which causes them to spontaneously abort. The only possible health education in such a case is to make the women aware of these hazards and hope that they will confine themselves to lighter tasks.

Despite legalisation, there are 39 lakh illegal abortions conducted in India resulting in 6.6 lakh deaths every year (The Daily, 17th February 1982). A study conducted in King George's Medical College (Lucknow) revealed that although 78% of the pregnancies were terminated in the 1st trimester, 67% of them had a history of interferences (Free Press Journal, 15th January 1983).

According to Ghosh (1983) insertion of a stick inside the uterus is by far the commonest method practised by the illegal abortionist. Other methods include forcing a stick of an

ingigenous root, an unsterilised rubber tube, soap solution or irritant chemicals.

It is not always a dai or a quack who performs an illegal abortion. There have been cases of nurses in hospitals who indulge in the practice. However septic abortion cases rarely divulge the names of the persons or clinics, hence it is difficult to track them down. The reason why unauthorised clinics or personnel are used, is largely because patients in the rural area are unaware of MTPs done in recognised clinics free of cost.

MATERNAL MORTALITY :

Talwalkar (1983) indicates that the maternal mortality rate per 1000 live births in India is 5.0. The maternal deaths in selected countries due to complications in pregnancy and or child birth are given below (UNICEF, 1983).

Table - X

MATERNAL DEATHS PER 1000 LIVE BIRTHS IN SELECTED COUNTRIES

Mozambique	6.50
India	6.00
Tunisia	3.10
Equador	2.10
Kenya	1.90
Jamaica	1.28
Rumania	0.31
The Netherlands	1.13

Also available is an analysis of the cause groups for maternal mortality in rural India for the year 1980 (Registrar General of India, 1982).

Table - IX

PERCENTAGE DISTRIBUTION OF MATERNAL MORTALITY DUE TO CERTAIN CAUSE GROUPS - 1980 INDIA (RURAL)

AGE GROUP	15 - 24	25 - 34	35 - 44
TOTAL NO. OF DEATHS	88	86	33
CAUSES	PERCENTAGE		
Abortion	13.7	8.1	21.2
Toxaemia	12.5	11.6	15.2
Anaemia	13.6	17.5	12.1
Bleeding of pregnancy and puerperium	13.6	23.3	3.0
Malposition of child leading to death of mother	12.5	11.6	21.2
Puerperial sepsis	15.9	8.1	15.2
Not classifiable	18.2	19.8	12.1
	100	100	100

A large proportion of deaths are caused due to absence of antenatal care in all the age groups. It has been estimated by various sources that anaemia is directly responsible for 20% of all maternal deaths (rural and urban combined) and is a contributing factor in another 20%.

ANAEMIA :

Anaemia is one of the major causes for the rapid aging of the woman in early years. It is especially prevalent among young children, women of reproductive age and during pregnancy. The causes of anaemia are multiple, but there is no doubt that young children and women are most affected because of their high requirements of iron and inadequate nutritional intake. It has been estimated that 230 out of 464 million women, or two-thirds of the women in developing countries are anaemia (WHO, 1982). In Asia itself, 65% of pregnant women and 57% of non-pregnant women suffer from nutritional anaemia.

Anaemia also lowers the natural resistance of the woman, thus making them more susceptible to infections. Post-puberty anaemia originates by the unreplaced blood loss which women suffer during menstruation. Without adequate nutrient supplies the blood formation will be deficient in the entire period until menopause.

The required daily allowance of iron for women is 30 mg., which is 10 mg. more than that for adult men (Gopalan, 1981). For pregnant women, this required daily allowance increases to 40 mg. and present social conditions do not cater to a diet which contains a sufficient amount of iron. This together with the high work demands made on the woman, makes anaemia a very common problem among pregnant women.

Around 60 to 80% of pregnant women in South India are anaemic (The Statesman, 20th July 1983). The prime cause is nutritional imbalance, not lack of a particular nutrient but an insufficient amount of food. However it is naive to talk of iron pills when the majority of those in the rural areas have still to be reached by any health services, or to recommend a balanced diet, however cheap, where sometimes there is no food at all.

EXCESSIVE WORK OF LONG DURATION :

It has been estimated that women perform nearly two-thirds of the working hours, receive one-tenth of the world's income and own less than one-hundredth of the world's property (UNICEF, 1983). In India it is estimated that 14-16 hours or nearly two-thirds of a woman's day is spent in working (Jain, 1979). Srilatha Batliwala (1982) states that the respective energy contribution of men, women and children are 31 per cent, 53 per cent and 16 per cent respectively. Hence the women are working longer and harder than the men. The following table gives an indication of the nature of these activities and the corresponding calorie expenditure based on a rural field study covering 3,452 population in 1980 (Batliwala, 1982).

Table - XII

ACTIVITY-WISE CALORIE EXPENDITURE PER DAY

ACTIVITY	CALORIE PER DAY		
	Man	Woman	Child
(A) Domestic			
(1) Gathering firewood	115	122	74
(2) Fetching water	7	232	40
(3) Carrying food to farm/ walking to farm	312	301	-
(4) Cooking	3	287	24
(5) Livestock grazing	274	68	155
SUB-TOTAL	711	1,010	293
(B) Agricultural			
(1) Ploughing	59	-	
(2) Irrigation	59	-	
(3) Transplanting	25	85	
(4) Weeding	25	85	
(5) Harvesting	57	51	
(6) Winnowing	-	24	
(7) Threshing	45	10	
(8) Manuring	31		
(9) Nursery	15		
(10) Harrowing	12	-	
(11) Transporting	6	-	
SUB-TOTAL	334	255	
(C) Other activities (sweeping, cleaning, child care, personal care, play, etc.)	878	715	655
(D) Rest and sleep (approx.)	550	500	650
T O T A L ...	2,473	2,505	1,598

Firstly, it is apparent that the net caloric expenditure per day of the woman is higher than that of the man. How does this relate to calorie intake? The same study looked at the pattern of food distribution within the family among men, women and children. The local dietary staple is the cereal ragi, which is cooked to a dough-like consistency and separated into fist-sized balls for eating. The distribution occurs in the following ratio : 2 balls for a man, 1.5 for a woman and 1.0 for a child. The relative calorie intake per man, woman and child works out to 3270 calories, 2410 calories and 1640 calories per day respectively. Hence there is a deficit of nearly 100 calories per day for the woman. Moreover, this deficit is felt more acutely during pregnancy and lactation when an additional 500-600 calories are required.

The next point to be noted is that women spend more hours a day on survival related activities such as fetching water (0.78 hours) and cooking (2.28 hours). Apart from the sheer drudgery of the work, it creates a high demand on human energy because of great distances between the home and resource centres, and/or existence of primitive technology. For example, in India there exist 57,000 villages where there is no water within a kilometre radius (Tuli, 1982). Hence, merely collecting a vital source of life leads to ailments such as backaches and worn out feet for women. The irony is that if only cooking fuel and water were readily available close to the user, and the efficiency of stoves improved, a saving of nearly 500 calories per day for women could be effected.

The present stoves used for cooking are not only primitive and inefficient, but also a potential health hazard for women. It has been estimated that women who spend around 3 hours a day cooking, inhale benzo-pyrene which is equivalent to smoking 20 packets of cigarettes a day (SNDT, 1983). The answer to this would be to promote an appropriate model of the smokeless 'chula', which is reported to have a fuel saving of nearly 50 per cent. The best way to initiate the widespread use of appropriate technology would be through the participatory research mode, combining the know-how of the innovation with the acumen of people at the grass-roots level (Batliwala, 1983b).

UTILISATION OF HEALTH SERVICES :

There are an extremely limited number of studies on the utilisation of health services by women. The only women - oriented programmes in the health sector have been maternal and child health schemes and to some extent family planning. The nutritional problem of women have always been considered that of pregnant or lactating mothers hence feeding programmes focus on this section. There is no doubt that these are essential services, however Kamala Jayarao (1983) has summarised the problem "as fundamentally an offshoot of a deeper, more complex malady, namely the inferior status and expendable nature of the female in Indian Society".

It is felt that women have less access to health services not because they are healthier or possess adequate health knowledge, but because their health is a low priority (Prakash, 1980). An examination of in and out-patient records of medical institutions reveals that for every 3 men who avail of these facilities, only one woman does so (Batliwala, 1981). The procedures of getting treatment in city hospitals is so cumbersome and time consuming that women cannot afford to wait for 3 hours before a doctor can see them, being so hard-pressed for house-work.

Women are also constrained to use facilities which are staffed primarily by men. India does have a higher percentage of female health workers than even many developed countries. However it is difficult to get them to accept postings in rural areas where the need is the strongest.

WOMEN AS HEALTH PERSONNEL :

Although there has been a steady improvement since 1961, the proportion of women in the cadre of grass root level health workers is still low (about 20%). Their representation in the teaching institutions is far below this proportion.

Table - XIII

NUMBER OF DOCTORS BY SEX AND QUALIFICATIONS REGISTERED UPTO 1979

GRADUATES		LICENTIATES		TOTAL	
Male	Female	Male	Female	Male	Female
1,60,297	53,259	53,259	2,935	1,94,687	46,194

SOURCE : Medical Council of India, as cited in Handbook on Social Welfare Statistics 1981, Government of India, 1982.

The sole exception is the obstetrics and gynaecology department which has more than double the number of male faculty members.

Nurses have been labelled the cursed women in the medical profession. The nurse : doctor ratio was 1:2.3, which is far from the ideal ratio of 3:1 (Sweden). The distribution of nurses is as follows (Bang, 1983).

Table - XIV

SEX CHARACTERISTIC

	MALE	FEMALE
General Nurses	5.83% (3979)	94.17% (64,273)
Auxiliary Nurse Midwives	0%	100% (41,522)

The profession is a very insecure one for women, and there is a high degree of sexual harassment, especially on night duty. In the remote villages where the ANMs are usually posted, they fall prey to the local leaders. It is no wonder then that a majority of the nurses come from a low socio-economic group and are forced into their profession.

Even the community health worker scheme defeated hopes when 80% of those selected and trained by the government were men. Sex segregation prevents them from reaching women and their children effectively. In a recent seminar held by the Voluntary Health Association of India (VHAI, 1983) it has been suggested that every alternate village be posted with one woman. In this arrangement the male CHW would take care of the male population in his own village and the neighbouring one, while the female CHW there would attend to the women and children in her own village and that of the male CHW village. It is not clear whether the idea would get implemented or what other problems it would generate.

What is clear is that women have always assumed the traditional role of looking after the health needs of the entire family. If this is recognised then the ANMs, CHWs and traditional mid-wives can form a strong infrastructure for community health care. Together they can manage more than 90% of the health problems of the community, especially that of women. Such a female network will greatly benefit the women of the rural areas who do not have any access to proper health care today.

CONCLUSION :

It can be seen from the above data that women's health is largely affected by their social status and tends to be neglected. A basic factor contributing to this neglect is male dominance at all planning and policy making levels. The female sector in economic and social development is largely outside the market economy. Women are involved in the subsistence sector of the economy which seldom receives attention in the statistics or development planning. The present definition of work or labour force is such that it excludes fifty per cent of the work which women do.

The paradox is that women have always been the main providers of health care throughout the world. Providing primary health care should include the participation of women. Monitoring pregnancies, adequate antenatal care, emphasising that nutrition implies not merely calorie intake but also calorie expenditure, family planning methods which are safe as well as effective, and immunisation are only some of the areas where women could be effective.

Most of all, an attempt should be made towards changing the attitudes about women's work load, recognising household work, health care and rearing of children as part of "work", so as to bring a better balance and sharing of responsibilities between men and women. Such measures will represent an investment in both present and future generations.

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